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ABSTRACT

This paper contends that, in a psychotherapeutic relationship, the client must experience himself or herself as deeply understood and unconditionally accepted by the therapist. This subjective experience of the client is seen as the quintessential dimension in successful psychotherapy. The paper goes on to state that the client's experience of being understood and accepted is a product of a specific pattern of client-therapist interaction and that, as a product of this process, the client begins to internalize these acceptance promoting client-therapist interactions, thus facilitating self-acceptance and greater psychic health. The necessary interactive pattern between therapist and client is discussed, and several steps in the process are identified: (1) the client develops a sense of safety in the therapy relationship and risks disclosing aspects of the self that are usually concealed; (2) the therapist receives and empathically understands the client's disclosures; (3) the therapist communicates this understanding to the client; (4) the client acknowledges that the therapist has understood; and (5) the client still believes in the therapist's acceptance. A section on the acceptance of experience explores why the experience of being deeply understood and unconditionally accepted by another person can itself be therapeutic. While it is hoped that the process of understanding and acceptance will be developed and carried through to the point where the client recognizes and integrates experiences previously denied to awareness and reduces psychic dissociations, it is recognized that the process can also arrest at any point, resulting in a therapeutic impasse. (NB)

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The Experience of Acceptance and the Acceptance of Experience

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THE EXPERIENCE OF ACCEPTANCE

AND THE ACCEPTANCE OF EXPERIENCE

Drevis L. Hager

Abstract

The author discusses the client's subjective experience of being deeply understood and unconditionally accepted by the therapist as the quintessential dimension in successful psychotherapy. This experience is typically brought about by a specific client-therapist interactive pattern. As a product of this process, the client gains a conviction that the therapist understands and fully accepts him or her, this sense of being accepted is progressively internalized by the client as self-acceptance, and experiences previously denied to awareness are recognized and integrated by the client. The therapy process can also arrest at any point, resulting in an impasse.

The Experience of Acceptance and the Acceptance of Experience

In his outline of what he considered the necessary and sufficient conditions for personality change in psychotherapy, Rogers (1957, 1959) listed the following:

> 1. That two persons are in contact.
>
> 2. That the first person, whom we shall term the client, is in a state of incongruence, being vulnerable, or anxious.
>
> 3. That the second person, whom we shall term the therapist, is congruent in the relationship.
>
> 4. That the therapist is experiencing unconditional positive regard toward the client.
>
> 5. That the therapist is experiencing an empathic understanding of the client's internal frame of reference.
>
> 6. That the client perceives, at least to a minimal degree, conditions 4 and 5, the unconditional positive regard of the therapist for him, and the empathic understanding of the therapist (1959, p. 213) (emphases in original).

As is well known, conditions 3, 4, and 5, the therapist's congruence, unconditional positive regard, and empathy, are the conditions that have been focused upon, researched, and debated for the past 30 years. In one respect, it is unfortunate that these therapist conditions have received so much attention, for in the process the most crucial condition -- condition 6 -- has been eclipsed. Consequently the most profound and helpful implication of Roger's formulation has been obscured. As Rogers explained, "it is not enough for the therapist to communicate, since the communication must be received, as pointed out in condition 6, to be effective" (1959, p. 213). "Unless some communication of (the therapist's) attitudes has been achieved, then such attitudes do not exist in the relationship as far as the client is concerned, and the therapeutic process could not, by our hypothesis, be initiated" (1957, p. 99) (emphasis added).

Keeping Rogers's condition 6 in mind, it becomes clear that only a slice of the vast research in this area has attempted to test Rogers's hypothesis in its complete form. Most studies of therapist conditions have utilized external raters to judge the therapists' degrees of congruence, empathy, and positive regard (as opposed to asking clients for their perceptions). And, as many reviewers have noted, the research has yielded mixed findings, with some studies reporting significant correlations between therapist conditions and outcome, and others not (Gurman, 1977; Lambert, et al., 1978; Mitchell, et al., 1977; Orlinsky and Howard, 1978; Parloff, et al., 1978). But as Patterson (1984) has indicated, had client ratings of the therapist been utilized in all of these studies, holding closer to Rogers's formulation, the collective record may have been largely confirming. Indeed, of the studies reviewed by Orlinsky and Howard (1978) that examined the client's

experience of the therapist, twelve of fifteen studies (80%) reported significant relationships between successful outcome and the client's view of the therapist as empathic and understanding. Of the three studies that did not detect significant relationships, two nevertheless evidenced strong trends in this direction. Also, of the thirteen studies reviewed by Orlinsky and Howard (1978) that examined the client's view of the therapist as affirming the client's value (positive regard), each of the thirteen found significant relationships between this dimension and successful outcome.

Clearly, then, it is the client's subjective experience that matters. It does not automatically follow that a therapist's or external rater's judgments are reflective of the client's. Therefore, if we are truly interested in bettering our understanding of the therapeutic process, then our starting point needs to be the client's subjective experience of therapy.

The Experience of Acceptance

What exactly is the client's experience when in therapy with a therapist who he or she has rated high in empathy and positive regard? It is unlikely that the client would naturally organize this experience along the lines of specific therapist conditions. Rather, it seems much more plausible that most clients experience the impact of these conditions. Rogers (1957) addressed this question:

> Since (the therapist's) attitudes cannot be directly perceived, it might be somewhat more accurate to state that the therapist behaviors and words are perceived by the client as meaning that to some degree the therapist accepts and understands him (p. 99) (emphasis added).

Thus, to restate Rogers's (1957) formulation strictly from the vantage point of the client, the essential condition for personality change in psychotherapy is that the client must experience himself or herself as deeply understood and accepted by the therapist. This is the central thesis of this paper. A corollary to this thesis is that the prognosis of a given case is more hopeful when the client is able to experience this understanding and acceptance consistently and convincingly.

A second thesis of this paper states that the client's experience of being understood and accepted is a product of a specific pattern of client-therapist interaction. An implication of this thesis is that the therapist's qualities alone are not "therapeutic," nor do they directly cause the client to feel accepted. Rather, the therapist qualities of empathy, congruence, and positive regard are important to the extent that they shape interactions that eventually lead to the client's experience of being understood and accepted.

A third thesis states that these acceptance promoting client-therapist interactions are progressively internalized by the client, thus facilitating self-acceptance and greater psychic health.

An Interactive Pattern

Why is it that a given client will eventually feel understood and accepted while another may not? What follows is a five-step interaction pattern that, it is hypothesized, the therapist and client must travel along if the client is to develop a sense of being deeply understood and accepted.

1. The client must (a) develop a sense of safety in the therapy relationship and (b) risk disclosing aspects of self that he or she usually conceals.

2. The therapist receives and empathically understands the client's disclosure.

3. The therapist communicates his or her understanding to the client.

4. The client must acknowledge (overtly or covertly) that the therapist has understood.

5. The client must believe that the therapist still accepts him or her.

When this interaction pattern occurs, the client is likely to experience a convincing sense of being understood and accepted by the therapist. The subjective intensity of this experience can range from a slight increase in ease to profound release.

Parenthetically, I am tempted to call this interaction pattern an interaction "sequence" because there is a clear temporal dimension that weaves through it. Certain interactive tasks generally and more obviously precede others. I have concluded, however, that the term interaction pattern is a better fit because elements of each "step" can be shown to facilitate and simultaneously occur with characteristics of other steps. For example, although the client must first risk and reveal himself or herself more fully (step 1), it is the therapist's ongoing understanding and communicating (steps 2 and 3) and the client's belief in the therapist's understanding and acceptance (steps 4 and 5) that afford the client the strength to risk more fully disclosing the self.

It is proposed that the more this particular pattern occurs in the course of therapy, the better the prognosis. Over time these acceptance promoting interactions are internalized, the client becomes increasingly more self-accepting, and various self-experiences previously denied to consciousness are identified, accepted, and integrated into the self-structure. Blocks to this process may also occur, especially as influenced by transferences and countertransferences, resulting in therapeutic impasses. Below is a discussion of each step in this interactive pattern.

Although the starting point of this paper has been client-centered theory and research, there is considerable overlap of the position taken

here with contemporary psychoanalytic formulations of therapy, especially the psychoanalytic phenomenology or intersubjective position articulated by Robert Stolorow and colleagues (Atwood and Stolorow, 1984; Stolorow, 1985; Socarides and Stolorow, 1985). Thus Stolorow's work, as well as that of other psychoanalysts, is referred to alongside that of Rogers.

1. The client must (a) develop a sense of safety in the therapy relationship, and (b) risk disclosing aspects of self that he or she usually conceals. The importance of this first step cannot be overstated. Rogers (1959) made this point clear when he said:

> If I know little or nothing of you, and experience an unconditional positive regard for you, this means little because further knowledge of you may reveal aspects which I cannot so regard. But if I know you thoroughly, knowing and empathically understanding a wide variety of your feelings and behaviors, and still experience an unconditional positive regard, this is very meaningful. It comes close to being fully known and fully accepted (p. 231).

Thus if the client does not reveal anything personally meaningful, then whatever so-called acceptance he or she experiences from the therapist will be quite shallow and will not have much of an impact.

I suspect that every client, to some degree, seeks therapy in order to find a person who will be understanding and accepting. Accordingly, each client is highly motivated to eventually make significant, non-superficial and very personal disclosures. But the reverse is also true: Each client fears that understanding and acceptance will not be there, and to that extent clients are motivated to protect themselves from insults. An ambivalent attitude is there from the start of therapy, and it is through time and experience with the therapist that the client overcomes his or her transference-based fears and builds plateaus of trust and willingness to "open up." If this trust does not build, then the process leading to feeling understood and accepted will not progress, and the psychotherapy arrangement will not actually be therapeutic. From the perspective taken here, the greatest value in working to diminish negative transferences lies in helping the client toward a new, healthier relationship with the therapist such that he or she may benefit from the understanding and acceptance available in the therapy interaction.

2. The therapist receives and empathically understands the client's disclosures. This step is very important because the therapist's subsequent responding will be an outgrowth of the specific conception he or she has of the client's subjective world. The therapist's empathic understanding is achieved by listening with an open mind (and gut) while self-introspecting in resonance with the themes heard in the client's disclosures. Empathy is a creative process. The therapist must compare the client's words and gestures with his or her own feelings, thoughts, memories, and concrete visceral reactions so that this wealth of data might be blended to approximate the client's actual subjective experience, thus creating an intersubjective conjunction (Atwood and Stolorow, 1984) between client and therapist.

With the above in mind it is possible to think in terms of depth or richness of empathy. The difference between merely understanding the facts of the client's disclosures and understanding the client's affective struggles can mean the difference between a simple restatement and a deep reflection or interpretation that truly illuminates the client's inner world. Empathic richness requires that the therapist enter again into historical areas of his or her own life that parallel the client's contemporary struggles, and to do so in such a way that the affective elements are momentarily awakened and used as meaning referents.

The therapist's countertransferences can drastically alter this empathic process, especially in instances where the therapist's defensive attempts to mitigate painful affect have left the therapist alienated from himself or herself and, therefore, unable to clearly comprehend the client's affective experience. Also problematic are situations where the therapist's affective struggles so closely parallel the client's that the therapist interprets the client's experience in ways that come close, but nevertheless miss the mark of the client's actual experience.

Although the therapist's empathic understanding is important, it is certainly possible that a client might come to believe that the therapist has understood when the therapist has, in fact, not understood. For according to the thesis of this paper, it is not the therapist's understanding per se that directly causes the client's belief that he or she is understood. It is doubtful, however, that a client would develop a convincing and sustained belief that the therapist understands when faced with frequent empathic failures. There is room for an occasional misunderstanding when within an overall context of understanding. When misunderstanding dominates, however, at best the client might experience a transitory sense of having been understood, and at worse such intersubjective disjunctions exacerbate the client's conflicts (Atwood and Stolorow, 1984).

3. The therapist communicates his or her understanding to the client. Unless the therapist effectively signals his or her understanding to the client, then this understanding might exist for the therapist only. Although it is conceivable that a client would feel consistently understood even though the therapist is not regularly communicating understandings, in actual practice the therapy process is vulnerable to breakdown in cases of chronic therapist non-communication. I suspect there are therapists who are empathic enough, but who do not help to the degree that they could simply because they do not communicate their understanding at times when the client needs to feel understood. Again, the therapist's countertransferences can seriously sway this step of the sequence, as can fanatical attachments to theoretical-technical mandates that therapy should take place in an atmosphere of privation.

Effectively communicating an understanding is a large portion of the art of psychotherapy. Communicating is not purely verbal. A lot can be communicated by a raised eyebrow, a nod, an affirming "m-hm," or a contemplative "hmm." The therapist's tone of voice, cadence, timing,

placing of emphases and silences, facial expressions, body movements, and so on all combine to form communications that can, on the one hand, profoundly illuminate the client's subjective experience or, on the other hand, leave the client with a sense that the therapist is miles away.

The specific wording of the therapist's understanding can significantly skew the communication. For example, Harry Guntrip, a psychoanalyst, in discussing his own analysis with W.R.D. Fairbairn, tells of an intellectualized interpretation offered by Fairbairn. In regard to Guntrip's troubled relationship with his mother, Fairbairn said "something forecloses on the active process in the course of its development" (Guntrip, 1975/1986, p. 453). Guntrip goes on to say, "I would have said: 'Your mother squashed your naturally active self'" (p. 453). It may have been that Fairbairn had the very same meaning in mind that is clear in Guntrip's phrasing, but his sterilized communication obscured whatever understanding may have existed.

4. The client must acknowledge (overly or covertly) that the therapist has understood. It is often assumed that if the therapist is able to empathically grasp and skillfully communicate the client's experience, then the client will automatically receive the communication and feel understood. This is not so automatic, however. In order for the client to feel understood, the client must first be open to the possibility, and recognize when another has indeed understood. The therapeutic process will proceed so long as the client remains open to the therapist's empathic understanding, and will become impaired to the extent that this openness is absent.

When the client recognizes that the therapist has understood, both are drawn closer psychologically. This is a crucial and pivotal point in the course toward feeling accepted. Both parties have articulated very similar conceptions of the client's subjective universe, and both recognize that this has happened. The client is now accompanied. This is a rare moment in life, one that might contribute to greater self-acceptance or, conversely, if the client believes that the therapist does not accept him or her, to strengthened self-loathing and shame.

People vary a great deal on this dimension of openness, and there are always transference influences involved. Each person brings into contemporary life the fears and protective maneuvers learned earlier. For some clients this openness is virtually unbearable, and consequently they erect rigid defenses to screen out others' opinions. Modell (1980) has described such a client as living in a self-spun "cacoon:"

> The cacoon is like a fortress in which nothing leaves and nothing enters -- it is not only that they do not communicate but they also do not receive the communication of others, they do not want to hear what is said to them (p. 261).

5. The client must believe that the therapist still accepts him or her. If the client is able to successfully remain open to the therapist's empathic understanding, she or her must also be able to conclude that the therapist still regards him or her positively. It is

not enough for the client to feel understood if this dyadic exchange is to have a mutative effect in the client's organization of experience. For if the client believes that the therapist, although understanding the client very well, harbors negative feelings and thoughts about the client, such a situation can quickly exacerbate psychic conflicts and shame.

In contrast, if the client is able to conclude that the therapist is accepting of him or her in spite of all that has been revealed (and understood), then psycho-therapy is occurring at that moment. The client has developed a trust of the therapist, has revealed the self more clearly and fully than previously, has felt understood and accepted, and thus has subjected split-off aspects of the personality organization to the integrative power of confirmation and acceptance. The client has gradually reassessed what was previously banished and/or hidden, and has tested this out in relation to the therapist. The continued and unwavering understanding and acceptance that the client comes to experience becomes the force that gradually transforms shame and guilt to heightened ease and affective freedom, and self-condemnation to greater self-acceptance.

Obviously if the therapist has a healthy liking of the client we can safely conclude that the client has a higher probability of feeling accepted than would be the case if the therapist did not like the client. The therapist conditions of genuineness and positive regard figure prominently at this interactive juncture. It is a conceptual error, however, to assume that the therapist qualities are alone responsible for the client's sense of acceptance; they are not. For, to repeat the quote from Rogers (1957), "unless some communication of (the therapist's) attitudes has been achieved, then such attitudes do not exist in the relationship as far as the client is concerned" (p. 99) (emphasis added).

What has been presented is an interactive pattern which, it is hypothesized, the therapist and client must travel along if the client is to feel understood and accepted. Thinking of psychotherapy in terms of an interactive process is advantageous in that the therapist is provided with a tool for conceptualizing the development and maintenance of the therapeutic relationship, and also for assessing impasses that periodically arise. In the event of a block to progress, the therapist can examine the steps in the process and locate the source of the difficulty: Is the client developing trust and disclosing meaningful material? Is the therapist receiving and empathically understanding the client's communications? Is this understanding being communicated to the client? Is the client leaving himself or herself open to the therapist's understanding? If so, what does the client seem to think the therapist's attitude is toward him or her? Difficulties at any point need to be addressed and worked-through in order for therapy to resume.

I do not consider this pattern to be the only therapeutic factor. I do believe, however, that this client-therapist process needs to be operative if psychotherapy is to be truly therapeutic. Is it enough, by itself, to bring about growth? I think the answer to this is "yes," in

many cases -- and for other cases more may be needed. There are certainly techniques that do not directly contribute to the client's self-acceptance, but that are nevertheless helpful. But I believe few if any interventions carry much power at all if the client does not feel understood and accepted by the therapist. In some cases, then, this process is sufficient, and in all cases it is necessary.

The Acceptance of Experience

Why is it that the experience of being deeply understood and unconditionally accepted by another person can itself be therapeutic? This question is addressed in this section. A simplified answer is that the experience of acceptance by another person helps to bring about greater self- acceptance and integration of self-experience. Structurally, this means fewer splits in the personality. In order to discuss this process in greater detail, a brief discussion of problems in the development of the self is presented.

The Self and Conditions of Worth

Rogers (1959) viewed the development of the self and of psychopathology as initially emerging within the context of child-parent interacting. Central to Rogers's theory is that the person strives, from a very early age and thereon, to gain the positive regard of significant others, especially his or her parents. Through experience the child learns that positive regard is gained under certain conditions -- these become the child's conditions of worth.

> The infant learns to need love. Love is very satisfying, but to know whether he is receiving it or not he must observe his mother's face, gestures, and other ambiguous signs. He develops a total gestalt as to the way he is regarded by his mother and each new experience of love or rejection tends to alter the whole gestalt. Consequently each behavior on his mother's part such as a specific disapproval of a specific behavior tends to be experienced as disapproval in general. So important is this to the infant that he comes to be guided in his behavior not by the degree to which an experience maintains or enhances the organism, but by the likelihood of receiving maternal love. Soon he learns to view himself in much the same way, liking or disliking himself as a total configuration. He tends, quite independently of his mother or others, to view himself and his behavior in the same way they have.... It is when he behaves in accordance with these introjected values that he may be said to have acquired conditions of worth. He cannot regard himself positively, as having worth, unless he lives in terms of these conditions (Rogers, 1959, p. 225).

The crucial point in Rogers's statement is that the child eventually comes to regard himself or herself in the same way that he or she perceives the parent as regarding him or her. Thus, the parent-child interactions are internalized and come to organize the child's self-experience.

I would like to emphasize a point that psychoanalyst Hans Loewald (1960) has made in regard to internalization: What is internalized is not only the image and words of the parent, but the interaction between child and parent itself. The interaction that was at first purely interpersonal becomes paralleled in the psychic organization of the child. The child develops a method of self-evaluating and acting toward self that replicates the recurring parent-child interaction patterns.

Stolorow (1985) has developed a position similar to that of Rogers. Stolorow states that the child's need to establish and maintain vital emotional ties with a parent can override most other motives and can, in circumstances of parental non-responsiveness and non-empathy, lead the child into patterns of self-rejection. A parent must be able to detect the developmental needs of the child and respond in ways that are harmonious with the felt needs. When the parent's ability to adapt to the child's needs is underdeveloped or impaired, the child is the one who must then adapt to the emotional needs of the parent. Just as in Rogers's formulation, the child learns what is required of him or her in order to preserve the highly valued tie to the parent. "Once the requirements become structuralized as invariant organizing principles of the child's subjective world (read conditions of worth), he will be vulnerable to painful feelings of guilt, shame, or anxiety whenever his inner strivings threaten to violate them" (Stolorow, 1985, p. 195). Defensive maneuvers are then necessary in order to protect the person from affects and other self-experience that might disrupt the person's sense of worth and positive self-regard (Rogers, 1959) or threaten the person's love ties (Rogers, 1959; Stolorow, 1985).

Furthermore, according to Stolorow's position, parental empathic attunement and responsiveness to the child's affective states facilitates the integration of affect into the self-structure. Greater integration leads to a firmer, more cohesive sense of self. Conversely, a fragile and fragmentation-prone self results when the child's emerging affects are not met with appropriate empathic mirroring.

> An absence of steady, attuned responsiveness to the child's affect states leads to minute but significant derailments of optimal affect integration and to a propensity to dissociate or disavow affective reactions because they threaten the precarious structuralizations that have been achieved (Socarides and Stolorow, 1985, p. 106).

The result of experienced failures in empathic responding is an array of possible psychopathological conditions ranging from intrapsychic conflict (neurosis) to weaknesses in the structuralization of the self (e.g., personality disorders). The basic underlying problem is the same, namely, fractioning of the personality -- whether due to self-rejection, rigid defenses, or lack of integration. What is optimally therapeutic is thus found in interaction patterns that are essentially antithetical to those that have led to this psychic fractioning. That is, the client needs a protracted experience of being deeply understood and accepted.

Understanding, Acceptance, Integration

> Dane, a 36-year-old man, came to therapy with vague and highly intellectualized complaints and stated that his major goal was to "get in touch" with himself. His incessant intellectualizing and nearly complete blotting out of affect contributed to the difficultly I experienced in keeping my attention on him, and for the first five sessions I was nearly always bored. Although initially denying any negative feelings toward either of his parents, he referred to his mother as "that person who we might call mother" and "that person who plays the part of mother," thus indicating simultaneously his distancing and disappointment in her. His mother, he said, would respond to his feelings and childhood difficulties by brushing them aside, instructing him to feel the opposite, or telling him to simply not feel at all. "Don't be sad," "I don't know why you're so upset," and "just forget about it" were her most used lines. As I listened to him and tried to understand and respond to whatever affect he could offer, he gradually began to soften and drop some of his intellectualizing. At the sixth session Dane disclosed instances when he indeed was angry, frustrated, and disappointed with his mother for her apparent lack of acceptance of his feelings. He then exclaimed that this talk of his anger was making him feel "bad;" it wasn't nice, he said, to speak of one's parents that way. I chose to empathize with and respond to the conflict he experienced in regard to the anger he was feeling. He then responded by disclosing an early but vivid memory: Dane had gone to his mother, sad and crying because he had been teased at kindergarten and contrary to what he expected, his mother simply listened. She put her arm around him and sat there beside him (he referred to her as "my mom" when telling this story). He recalled the wonderful sense of simply having his mother listen to him and not tell him "don't be sad." He then began to cry (in the session) and said, "I remember I felt she just understood me, I felt accepted by her. At that moment I really felt like I was myself completely and not someone's appendage."

This case vignette illustrates a number of points. First, Dane's therapeutic goal to "get in touch" with himself illustrates some conscious awareness of the self-alienation produced by his defense against affect.

Second, it can be seen that the sadness and anger Dane felt as a child ran counter to his conditions of worth. He expected his mother to respond, not with empathy and soothing, but with instructions to feel differently. Negative affects were distressing to him, in part, because they implied that he was bad or wrong and wouldn't be loved.

Third, it is important to note that when his mother responded in an accepting and caring manner -- not instructing Dane to feel differently -- he was able to feel understood and accepted and to momentarily suspend his conditions of worth and allow his self-experience to emerge fully ("I really felt like myself completely..."). This experience of himself was in sharp contrast to his usual experience of trying to live

in accordance with what he believed his mother required of him (e.g., his experience of himself as "someone's appendage").

Fourth, the vignette also illustrates how Dane more fully revealed aspects of himself in therapy as a consequence of feeling understood. Contrary to his expectations, he found that his affective disclosures were met with understanding and acceptance which, it is hypothesized, elicited the memory of feeling understood and accepted by his mother.

The positive instance that Dane had with his mother is a model for the sort of interacting that must occur in psychotherapy if it is to be effective. In the therapy relationship, just as with parent and child, specific communications can be made available that can help an individual develop or restructure his or her experiential organization so as to allow greater affective freedom, self-acceptance, and a firmer sense of self. When past and present wounds and hidden aspects of the self can be shared with another person, given that some attachment exists, the other's protracted and reliable empathic responding helps to open various experiential avenues and develop in the person a sense of being essentially understandable, acceptable, and whole. Each time the client moves to deeper disclosures and allows himself or herself to feel both understood and accepted, there is a slight modification in the self-structure. What once was unacceptable in terms of his or her conditions of worth is increasingly brought into the sphere of acceptability. Ornstein and Ornstein (1985), analysts from the self psychology camp, discuss this process from the standpoint of the development of <u>self-cohesion</u>:

> The acceptance and understanding of the infantile wishes (repressed or disavowed) and their defenses lead to the patient's subjective feeling of being understood in depth. The feeling of being understood aids the patient in establishing a (special relation to the therapist) in which understanding continually reinforces the stability and cohesiveness of the self. Self-cohesion increases as the split-off parts of the self are progressively included with the firmed-up core of the self. Increased and sustained self-cohesion leads secondarily to improved functioning in diverse ways and in many areas (p. 60-61).

It is proposed here that this psychic restructuring occurs because, as suggested by Loewald (1960), the client is gradually internalizing the interaction patterns that characterize the client-therapist relationship. As was the case between child and parent, the client-therapist interactions become the prototype for how the client eventually regards himself or herself, with the functions originally provided by the therapist becoming gradually performed by the client toward himself or herself. Thus if the interaction is largely comprised of a sequence of disclosure-understanding-acceptance, then this becomes increasingly established intrapsychically: The client comes to organize experience in ways that allow greater awareness, understanding, and acceptance of self-experience. A snowball phenomenon can occur where heightened self-acceptance affords the individual the strength to identify other split-off self-experiences and, subsequently, integrate these as characteristics of himself or herself. The individual's

conditions of worth are broadened, intrapsychic conflicts are minimized, and the sense of self is strengthened.

Summary

The client's subjective experience of being deeply understood and unconditionally accepted by the therapist has been discussed as the essential dimension in successful psychotherapy. This client experience is typically brought about by a specific client-therapist interactive pattern. As a product of this process, the client's sense of being accepted by the therapist is progressively internalized by the client as self-acceptance, experiences previously denied to awareness are recognized and integrated by the client, and psychic dissociations are thereby reduced. The process can also arrest at any point, resulting in a therapeutic impasse.

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